Present on Admission (**POA**) Indicator Reporting

by

Acute Inpatient Prospective Payment System (**IPPS**) Hospitals

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Overview

The Deficit Reduction Act of 2005 (DRA) requires a quality adjustment in Medicare Diagnosis Related Group (DRG) payments for certain hospital-acquired conditions. CMS has titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC & POA). Inpatient Prospective Payment System (IPPS) hospitals are required by law to submit POA information on diagnoses for inpatient discharges on or after October 1, 2007.
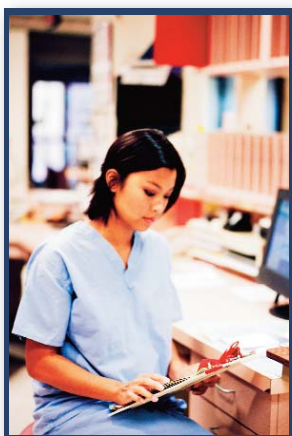
Affected Hospitals

The Present on Admission Indicator Reporting requirement applies only to IPPS hospitals.

At this time, the following hospitals are EXEMPT from the POA indicator requirement:

• Critical Access Hospitals (CAHs)
• Long-Term Care Hospitals (LTCHs)
• Maryland Waiver Hospitals
• Cancer Hospitals
• Children's Inpatient Facilities
• Inpatient Rehabilitation Facilities (IRFs)
• Psychiatric Hospitals

Phased Implementation for POA

October 1, 2007
IPPS hospitals are required to begin submitting POA information on all primary and secondary diagnoses on their Medicare claims.

Important Note: Because Direct Data Entry (DDE) screens cannot be updated until January 1, 2008, hospitals that submit claims via DDE will be unable to submit the POA Indicator until January 1, 2008.

January 1, 2008
CMS will begin processing POA data and will provide feedback regarding POA reporting errors through Remark Codes on the Remittance Advice. During the period of January 1, 2008 through March 31, 2008, hospitals will not be subject to returned claims.

April 1, 2008
Claims that are submitted for payment that do not contain proper POA data will be returned to the provider for correct submission of the POA information.

General Reporting Requirements

- The POA indicator is required for all claims involving Medicare inpatient admissions to general acute care hospitals.

- POA is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA.

- POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the *ICD 9-CM Official Guidelines for Coding and Reporting*).

- Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.

- If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guidelines, then the POA indicator would not be reported.

- CMS does not require a POA indicator for the external cause of injury code unless it is being reported as an "other diagnosis."

Coding

Use the *UB-04 Data Specifications Manual* and the *ICD-9-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the POA indicator for each "principal" diagnosis and "other" diagnosis codes reported on the UB-04 and ASC X12N 837 Institutional (837I).

These guidelines are not intended to replace any guidelines in the main body of the *ICD-9-CM Official Guidelines for Coding and Reporting*. The POA indicator guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-9-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the *ICD-9-CM Official Guidelines for Coding and Reporting*, a joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

Documentation

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission. In the context of the official coding guidelines, the term "provider" means a physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.

NOTE: Providers, their billing offices, third party billing agents, and anyone else involved in the transmission of this data must ensure that any resequencing of diagnosis codes prior to their transmission to CMS also includes a resequencing of the POA indicators.

POA
HAC

CMS POA Indicator Reporting Options and Definitions

CODE	REASON FOR CODE
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Exempt from POA reporting. This code is the equivalent code of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1.

Paper Claims

On the UB-04, the POA indicator is the eighth digit of Field Locator (FL) 67, Principal Diagnosis, and the eighth digit of each of the Secondary Diagnosis fields, FL 67 A-Q. In other words, report the applicable POA indicator (Y, N, U or W) for the principal and any secondary diagnoses and include this as the eighth digit; leave this field blank if the diagnosis is exempt from POA reporting.

For More Information

The HAC POA web page at *http://www.cms.hhs.gov/HospitalAcqCond/* provides further information, including the links to the law, regulations, change requests (CRs), and educational resources including presentations, MLN articles, and fact sheets.

Electronic Claims

Using the 837I, submit the POA indicator in segment K3 in the 2300 loop, data element K301.

Example 1
POA indicators for an electronic claim with one principal and five secondary diagnoses should be coded as **POAYNUW1YZ**.

POA — "POA" is always required first, followed by a single indicator for every diagnosis reported on the claim.

Y — The principal diagnosis is always the first indicator after "POA." In this example, the principal diagnosis was present on admission.

N U W 1 Y
- The first secondary diagnosis was not present on admission, designated by "N."
- It was unknown if the second secondary diagnosis was present on admission, designated by "U."
- It is clinically undetermined if the third secondary diagnosis was present on admission, designated by "W."
- The fourth secondary diagnosis was exempt from reporting for POA, designated by "1."
- The fifth secondary diagnosis was present on admission, designated by "Y."

Z — The last secondary diagnosis indicator is followed by the letter Z to indicate the end of the data element.

Example 2
POA Indicator for an electronic claim with one principal diagnosis without any secondary diagnosis should be coded as **POAYZ**.

POA — "POA" is always required first, followed by a single indicator for every diagnosis reported on the claim.

Y — The principal diagnosis is always the first indicator after "POA." In this example, the principal diagnosis was present on admission.

Z — The letter Z is used to indicate the end of the data element.